HEALTH CARE–ACQUIRED INFECTIONS

IPs Need Hospital Leaders To See Growing HAI Threat

CONFERENCE COVERAGE
IAHCSMM’s Leaders
Trumpet Sterile Processing’s
Unsung Heroism

CONFERENCE COVERAGE
Infection Prevention
Takeaways From IDWeek
2021 Conference

HAND HYGIENE
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COVID-19
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Everyone Plays a Role in Infection Prevention

The COVID-19 pandemic catalyzed an unprecedented awareness around infection prevention. An elevated understanding of the spread of pathogens and strict adherence to infection prevention practices, including cleaning and disinfection, was emphasized across healthcare. Infection Preventionists and Environmental Services are now commanding a new status in the spectrum of care. We are entering a period of change that — provided we sustain the lessons learned — has the potential to create a safer healthcare system for patients and professionals alike.

COVID-19 Revealed the Need for Better Infection Prevention

Across the country, the pandemic revealed cracks in our healthcare system — from staffing issues to complex and ever-changing guidelines and regulations because of the singular focus on COVID-19. Reporting for other healthcare-associated infections (HAIs) was given less priority. Now is the time to recognize the importance of continued diligence to protect patient, visitor and staff spaces from other pathogens that are easily transmitted from contaminated surfaces.

COMING TOGETHER TO HELP KEEP PATIENTS HEALTHY

In the face of a highly contagious, novel pathogen, healthcare workers banded together in their shared responsibility for infection control practices to protect patients and each other. But the pandemic also heightened awareness of the need for more frequent and thorough disinfection of high-risk surfaces and surfaces in the immediate patient environment. Furthermore, it accelerated interest in the adoption of effective and efficient solutions within healthcare facilities. Establishing proven cleaning and disinfecting practices can positively impact defense against the future of emerging pathogens that have little to no antibiotics to treat them.

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As the healthcare industry’s most trusted brand, Clorox Healthcare provides evidence-based solutions that kill a wide range of pathogens and are associated with a reduction in HAIs. Our ready-to-use product portfolio helps reduce human error and is rigorously tested and clinically proven. We also offer expert consultation and training. Despite the heavy demands of the pandemic, we saw healthcare workers taking a more active role in cleaning and disinfection. Then and now, Clorox Healthcare is committed to advancing these lessons to help create a more resilient healthcare system.

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We considered making the headline a statement rather than a question. The Delta variant peters out and infection, hospitalization, and mortality rates plummet. As of this writing, We’ve been fooled by COVID-19 before. Still, optimism sprouts as Thanksgiving Day nears.

Our coverage of IDWeek 2021 on page 28 features an interview with renowned infection prevention and control expert Monica Gandhi, MD, MPH. In the video of the interview on the Infection Control Today® (ICT®) website, Gandhi says, “In the history of infectious diseases, there has not been a single infection we haven’t been able to get through.” Let’s run with that.

Meanwhile, infection preventionists (IPs) still have plenty to do. Our cover story on page 16 by Heather Saunders, MPH, RN, CIC, a member of ICT®’s Editorial Advisory Board (EAB), reports on how IPs and hospital administrators can be agents of change, especially when it comes to battling health care-acquired infections. These pathogens have not been on vacation since that infamous month of March 2020.

On page 24, we look at the concerns of sterile processing professionals voiced at the annual conference of the International Association of Healthcare Central Service Materiel Management. (In January 2022, that organization will be renamed the Healthcare Sterile Processing Association.) We interview Damien Berg, IAHCSMM’s vice president for strategic initiatives, who tells us how these niche professionals “got known” during the pandemic.

If COVID-19 finally recedes, we will still have to deal with the aftereffects. Jan Dyer on page 20 discusses ways to battle a COVID-19–fueled steep rise in methicillin-resistant Staphylococcus aureus.

We here at ICT® continuously strive to give IPs the best information: news they can use. You can help. Send feedback to Vice President of Content Alexandra Ward at award@mjhlifesciences.com.

Thank you for reading,
Mike Hennessy Sr
Chairman and Founder
MJH Life Sciences™
Are You Going to Eat That? Be Careful

I am always willing to take a seat at your dinner table. Of course, you cannot see me and you certainly did not invite me. Actually, you did invite me—by your action or inaction. You did not clean or prepare your food properly, or you did not check to see how the manufacturer made your food. I am everywhere—moist environments, soil, water, decaying vegetation, and animals—so you cannot avoid me. Usually, I am harmless, but for some of you I can be devastating.

I am transmitted wherever food is processed, harvested, packed, prepared, or transported. Refrigeration is no guarantee I will not appear. I can grow and spread unless you set the refrigerator to 40 °F (4 °C), and the freezer to 0 °F (–18 °C).

Relatively speaking, I am not that big a threat. The Centers for Disease Control and Prevention says I infect about 1600 Americans a year, killing about 260. So I am not that dangerous...except when I am. And I said “relatively speaking.” The relatives of yours who are among my primary targets include pregnant women and infants. If I infect a pregnant woman, I can kill the child she is carrying. Newborns I have infected can become very sick and could even die.

I also can feast on individuals 65 or older and those with weakened immune systems.

Even if you can brush off my mortality rates, you really do not want me to infect you. My symptoms can last from days to several weeks.

They include:
- Muscle aches
- Nausea
- Diarrhea
- Fever
- Chills

If I spread to your nervous system, those symptoms are:
- Stiff neck
- Headache
- Loss of balance
- Confusion
- Convulsions

In outbreaks that I have caused, I lived in raw, unpasteurized milk and cheeses, raw or processed fruits, raw or undercooked poultry, raw or smoked fish, deli meats, sausages, and hot dogs. I can infect your pets and they in turn can infect you. I can even be found in ice cream. How mean is that?

To keep me away, keep it clean. Scrub your refrigerators, including the walls and shelves. Clean countertops, utensils, and cutting boards that you suspect might have been in contact with contaminated food. Next, sanitize them with a solution made of a tablespoon of bleach to a gallon of hot water. Dry these with a clean cloth or unused paper towel.

You know how spills in the refrigerator can stay, well, spilled? Good for me; not so good for you. Clean them right away.

I mentioned pets. If you want to avoid me, thoroughly wash bowls and dishes pets eat from as soon as they are done with their meals.

Here is something I am sure will surprise you: Proper hand hygiene also helps keep me at bay. Proper hand hygiene became all the rage when COVID-19 struck, but some studies suggest it has tapered off. Individuals forget. Just like I bet you will forget all that I just said.

Who am I? 

To discover who I am, visit InfectionControlToday.com/view/nov-2021-bug-month
Infection preventionists (IPs) face myriad challenges during COVID-19 surges, including changing IP guidance, acute shortages in personal protective equipment (PPE), understaffing, increased workloads that lead to burnout, and a rise in health care–acquired infections (HAIs). These problems affect all health care settings but hit nursing homes and other long-term care facilities (LTCFs) particularly hard, according to a study published in the *American Journal of Infection Control* (AJIC).1

Judging by what investigators with the University of St Louis found, the government’s allocation of $2.1 billion to bolster infection prevention2—with emphasis on improving care at LTCFs—will likely be welcomed by IPs everywhere but especially those at LTCFs. The findings also underscore the critical role IPs play in COVID-19 response.

The AJIC study “identified challenges IPs faced during the COVID-19 pandemic, including rapidly changing and conflicting guidance, lack of recommendations for nonacute care settings, insufficient PPE, PPE complacency, and increases in HAIs and workload. The identified gaps in pandemic response need to be addressed to minimize HAIs and occupational illness. In addition, the educational topics identified by participating IPs should be developed into new educational programs and resources.”

Investigators conducted 7 focus groups comprising members of the Association for Professionals in Infection Control & Epidemiology in September and October 2020. The IPs in the focus groups were drawn from LTCFs, acute care, outpatient, and rural health care settings. Participants included new (3 or fewer years’ experience) and experienced IPs (more than 10 years’ experience). The focus groups occurred over Zoom and participants were asked open-ended questions about their experiences.

A total of 73 IPs participated from across the United States. Nearly all (70) were female, with 40 individuals holding bachelor’s degrees and 32 with certification in infection prevention and control (CIC), and 1 had neither. Forty-nine worked in hospitals, 26 worked in LTCFs, and the rest worked in outpatient or other settings.

One IP says in the study, “We were heroes at first, bringing in the PPE that everyone wanted, but then we were the much-hated enforcers making [individuals] wear PPE, especially the face shields and goggles.” Respondents also discussed dealing with changing guidance. One IP relates how “CDC comes out and says ‘Use N95s,’ and then a couple weeks later they say, ‘Oh, if you just wear face masks, you’re OK, but N95s are preferred.’ It was very frustrating.”

The focus on COVID-19 forced IPs to forego their regular infection prevention duties. One explains, “There is no Monday through Friday. It is literally 24 hours a day, 7 days a week.”

Although they were desperately needed in the wards, IPs said they too often were left out of the decision-making process. This created a ripple effect, one says: “Decisions were being made in organizations...”
Sepsis Sufferers Receiving Antibiotics Quicker

BY INFECTION CONTROL TODAY® EDITORIAL STAFF

The faster that patients suffering from sepsis receive antibiotics, the better their chances for survival are. However, there still needs to be concern about possible adverse effects and contributing to antibiotic resistance, which could render the medications useless later.1 That was among the findings in a large cohort study published in JAMA Network Open, with another being that median time-to-antibiotics for sepsis declined by more than 9 minutes per year during the course of the study.2 Investigators with the University of Michigan and the US Department of Veterans Affairs (VA) also found that there did not seem to be a standardized approach concerning when to administer antibiotics. The study included 111,385 hospitalizations for sepsis at 130 VA hospitals nationwide from 2013 to 2018. The primary outcome was time-to-antibiotics across study periods, hospitals, and patient subgroups based on presenting temperature and blood pressure.

“[Although] time-to-antibiotics declined overall and in nearly every hospital during the study, there remained more than 2-fold variation in median time-to-antibiotics in the most recent study years,” the study states. The variation remained even after investigators adjusted the data to account for different patient characteristics. “This may represent a potential opportunity for practice improvement going forward, but the benefits of further accelerating time-to-antibiotics must be balanced against the risk of driving antibiotic overuse in patients with noninfectious illness,” the study states.

A good place to start, the study indicates, would be better monitoring of patients with abnormally low blood pressure (hypotension). The study states that “time-to-antibiotics was faster for patients with fever and normal blood pressure than for patients without fever but with hypotension, suggesting that obvious signs of infection are a stronger trigger to prescribe antibiotics than shock or that competing without their [IPs], which were resulting in extreme difficulties in coordinating throughout the county.”

IPs also noted an increase in HAIs. “The IPs in this study noted several factors they believed contributed to the increase in HAIs, including frequently changing protocols, staff turnover, lack of resources for training new staff, and visitor restrictions,” the study states. “Some IPs also described an increased placement of femoral central lines, which could increase risk for CLABSI [central line–associated bloodstream infection]. Increased workloads reported by the IPs to address the pandemic may have also adversely affected routine surveillance and practice observation, which could have contributed to higher HAI rates.”

LTCFs struggled the most. The study states that “IPs in LTCFs faced unique challenges not identified by their colleagues in acute care and outpatient settings. They were significantly more likely to run out of N95 respirators, reported challenges with COVID-19 testing not seen in other settings, experienced low staff morale, and saw high staff turnover. All of these factors exacerbated existing challenges to safe LTCF health care.”

LTCFs were devastated by COVID-19 outbreaks among staff and residents. The morbidity and mortality rates remained high even after vaccines became available, the study states. □

REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM
Most patients (68.7%) received their first dose of antibiotics in the emergency department. A total of 7574 patients (6.8%) died in the hospital, and longer time to antibiotics was associated with higher in-hospital mortality. A total of 13,855 patients (12.4%) died within 30 days of discharge.

The median time-to-antibiotics (adjusted for patient characteristics) declined by 9 minutes per calendar year but varied significantly between hospitals, with average time-to-antibiotics in the most recent period ranging from 3.1 to 6.7 hours. Overall, the unadjusted median time-to-antibiotics decreased from 4.5 hours in the first year of the study to 3.5 hours in the most recent year.

Max Wayne, MD, fellow in pulmonary and critical care medicine at the University of Michigan, told Infection Control Today’s sister publication Contagion® that “our findings suggest that patients with more obvious signs of infection get antibiotics faster. However, it is important to be cognizant that some patients with subtle findings can nonetheless still be very sick due to infection and warrant early antibiotics.”

The study also notes that “slope of change over time varied across hospitals in this initiative, resulting in a growing disparity in time-to-antibiotics by race as hospitals treating higher proportions of Black patients experienced less decrease over time.”

For patients in hospitals with faster time-to-antibiotics, the odds of receiving antibiotics within 3 hours increase by 65%. Median time-to-antibiotics during the most recent year of the study (3.9 hours) varied depending on presenting characteristics. Wayne said that “fever seemed to be a stronger driver of rapid antibiotics than low blood pressure.”

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Should Health Care Workers Reinforced With COVID-19 Quarantine?

Although COVID-19 vaccines work, they do not guarantee that a vaccinated person will not be reinfected, according to a research letter published in JAMA Network Open that examined breakthrough infections among health care workers (HCWs). Investigators reviewed data from 5312 fully vaccinated and 690 unvaccinated HCWs at the Hadassah University Medical Center in Jerusalem, Israel. The vaccinated workers received 2 doses of the Pfizer/BioNTech vaccine.

Contact tracing for the breakthrough infections found that 15 of the 27 vaccinated staff who experienced breakthrough infections became infected by a member of their household.

“This case-control study found that exposure to SARS-CoV-2–positive household members was a risk factor associated with infection among vaccinated HCWs,” the research letter states. “Household exposure is usually longer and closer than casual exposure or exposure at work and does not include masking or distancing, thus exposing one to a higher infectious dose and being more contagious.”

Investigators argue that their findings suggest that individuals exposed to someone in their household who has tested positive for COVID-19 be quarantined. “The findings of this case-control study suggest reconsideration of quarantining vaccinated individuals who have had significant exposure to household members who are positive for SARS-CoV-2 infection,” the research letter states. “This policy has already been implemented successfully in our hospital. Coupled with the current emergence of the SARS-CoV-2 Delta variant in Israel and worldwide, our proposal should apply not only to HCWs but to the general population.”

REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM
Method That Repels Pathogens From Hospital Surfaces Is Studied

BY FRANK DIAMOND

Two hours’ exposure to reformulated quaternary ammonium polymer coating applied to stainless steel coupons led to a reduction in contamination of stainless steel surfaces by human coronavirus 229 E (HCoV 229 E) and SARS-CoV-2 by more than 99.9%, according to a study published in the *American Journal of Infection Control.*

“With the recent detection of infectious SARS-CoV-2 from the bedside table, remote control, bed rails, and flooring in the hospital room of an infected patient, the importance of effective hygiene protocols for environmental surfaces remains imperative,” the study states.

Investigators with the University of Arizona used acetone-washed, preautoclaved stainless-steel coupons coated with reformulated quaternary ammonium polymer. The uniformity of the coverage was monitored by an x-ray fluorescence spectrometer. A control group of stainless steel coupons was not coated.

Both the control and experimental coupons were then exposed to HCoV 229 E and SARS-CoV-2, the virus that causes COVID-19. The study states that all work involving SARS-CoV-2 was done in a Biosafety Level 3 laboratory.

The viruses were harvested using both a carrier wash method and a swab method, with the carrier wash method proving more effective.

Swabs predipped in Letheen Broth Base (LBB) were placed into tubes containing 1 mL of LBB and mixed. “The suspensions were immediately passed through Sephadex G-10 gel columns by centrifugation,” the study states. The carrier wash method involved rinsing the carriers 4 to 5 times using 1 mL of LBB, and then a cell scraper to detach virus further. Investigators say more studies will hopefully assess the effectiveness of the method on a variety of porous and nonporous surfaces.

The study states that “surface-active coatings that have antiviral capabilities are not meant to substitute for regular cleaning and disinfection practices, but rather serve as an additional barrier for reducing human exposure to infectious viruses that may be present on fomites.”

Charles P. Gerba, PhD, one of the study’s authors, told *Infection Control Today* in May 2020 that continuously acting disinfectants will help environmental service teams keep health care facilities—and schools and office buildings—better protected from deadly pathogens. Gerba is the professor of microbiology and environmental sciences and a professor of public health at the University of Arizona’s Mel & Enid Zuckerman College of Public Health.

“The problem with many disinfectants [is that] they will inactivate or kill what’s on there, but these surfaces can become contaminated right away again,” Gerba told *ICT*. “And that’s the role of the continuously acting disinfecting surfaces because we know the surfaces are going to be continually contaminated. I think they might play another important role too, in that we emphasize largely the high-touch areas as playing the major role in disease of infectious organisms in the spread in indoor environments, but the low-touch areas are also important. I think we ignore them a lot.”

REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM
The Biden administration unveiled a $2.1 billion package on September 17, 2021, to improve infection prevention and control measures against COVID-19 and other emerging infectious diseases as part of the $1.9 trillion American Rescue Plan. Rochelle Walensky, MD, MPH, director of the CDC, said in a news release that the “funding will provide significant resources to our public health departments and health care systems and opportunities to develop innovative strategies to protect every segment of the US population, especially those disproportionately affected by the pandemic, at a time that they are hit hard.”

Just how much Walensky pushed for this move is unclear, but when she became CDC director earlier this year many infection preventionists took heart because of her extensive background in infection prevention and control. Priya Nori, MD, medical director of the antimicrobial stewardship program at Montefiore Health System, told Infection Control Today® during a Q&A in March that “the infectious disease community in particular is incredibly thrilled about the new CDC director. She is a woman who spent her years researching HIV, who was seeing patients for many years—who knows what it is like to be on the front lines.”

Over the next 3 years, the CDC plans to issue $1.25 billion of the funding to 64 state, local, and territorial health departments to support the effort. The funding will go to about 6000 hospitals, 15,400 nursing homes and other LTCFs, 7900 dialysis clinics, and 4700 ambulatory surgery centers. The allocations total $885 million, of which $500 million will go to what the CDC calls “strike teams” that will focus on LTCFs. The CDC says the strike teams “will allow state and other jurisdictional health departments to staff, train, and deploy strike teams to assist skilled nursing facilities, nursing homes, and other long-term care facilities with known or suspected COVID-19 outbreaks. The strike teams will allow jurisdictions to provide surge capacity to facilities for clinical services; address staffing shortages at facilities; and strengthen infection prevention and control activities to prevent, detect, and contain outbreaks, including support for COVID-19 vaccine boosters.”

In addition, the funding is meant to:

- Strengthen states’ capacity to prevent, detect, and contain infectious disease threats across health care settings. This will involve significant infection prevention and control assistance to public health departments to work with health care facilities to improve quality of health care, and efforts to minimize infection in various health care settings.
- Increase laboratory capacity for health care: This will improve surveillance of emerging pathogens to better identify patients infected with non–COVID-19 pathogens such as carbapenem-resistant Enterobacteriales and Candida auris. “Throughout the pandemic, there have been outbreaks of antibiotic-resistant pathogens in COVID-19 units and other health care settings,” the CDC states.
- Project Firstline: Funding will be increased for this effort meant to teach basic infection prevention and control methods to all health care workers.
- National Healthcare Safety Network: The CDC hopes to increase funding for states to better monitor infections in health care settings.
- Antibiotic Stewardship: Money will help in analyses of data about antibiotic use and will improve antibiotic prescribing, according to the CDC. “Despite being ineffective against COVID-19, antibiotics have been commonly prescribed to patients during the pandemic, increasing the risk of antibiotic resistance,” the CDC states.

REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM
Medical experts intend to take a closer look at long COVID-19, one of the more troublesome unknowns of the pandemic. Individuals who suffer from long COVID-19 exhibit acute symptoms from SARS-CoV-2 infection that can linger for months. Experts do not know whether they can do so for years; the disease has not been around long enough to make that determination.

The National Institutes of Health (NIH) on September 15, 2021, unveiled a $470 million study it hopes will mine data from 30,000 to 40,000 individuals who suffer from long COVID-19.1 The effort is called the REsearching COVID to Enhance Recovery (RECOVER) Initiative.2

NIH Director Francis Collins, MD, PhD, voiced some questions driving the need for answers. For instance, what causes long COVID-19? (The scientific name for long COVID-19 is PASC [postacute sequelae of SARS-CoV-2]).

Collins asked: “Is it a misfiring of the immune system that fails to reset after the infection with this coronavirus? Is it a triggering of some metabolic dysfunction? We don’t know.”

The CDC, in a recent study in its Morbidity and Mortality Weekly Report, says long COVID-19 symptoms exceed 4 weeks “among [individuals] who self-reported ever receiving a positive SARS-CoV-2 test result with the prevalence of similar symptoms among [individuals] who reported always receiving a negative test result.”3

The self-reported aspect of long COVID-19 tracking matters because medical experts, as Collins said, still do not know what it is. Self-reporting will be an important element of RECOVER; the NIH has set up a website where volunteers may sign up.

The CDC says long COVID-19 symptoms can include hair loss, cognitive dysfunction, muscle pain, headache, and joint pain.

Collins said that “the diversity of symptoms and presentations leads us to believe that long COVID-19 is not just 1 condition. The only way, therefore, we’re going to sort this out is with very large studies that collect lots of data about symptoms, physical findings, and laboratory measures.”

RECOVER will involve more than 100 researchers at over 30 institutions across the United States. As with everything involving an ever-mutating virus, getting the information quickly matters. Among the sources for data will be wearable

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BY FRANK DIAMOND
Telehealth Use Surges, but Satisfaction Declines

BY TODD SHRYOCK

The COVID-19 pandemic drove many patients and physicians to adopt telehealth as a safe, convenient way to access care at a time when many offices were closed and travel caused concern. However, it wasn’t always a smooth transition, according to the J.D. Power 2021 U.S. Telehealth Satisfaction Study. Usage of telehealth soared 36% in the past year, but the study also underscores that challenges remain before there is widespread acceptance of telehealth as a substitute for face-to-face patient/physician interaction.

Along with the up tick in usage, there was a perceived decline in customer service, with service limitations, difficulty accessing care, and inconsistent care listed as areas in which telehealth needs to improve.

Other study findings include the following:

- Telehealth embraced by all ages in 2021: During the past year, 36% of patients have accessed telehealth services. That’s an increase from 9% in 2020 and 7% in 2019. Usage was consistent across generations, with the highest engagement reported by millennials (born between 1981 and 1996) and the generation before Baby Boomers.

- Keep things easy, fast, and safe: The top telehealth motivators cited were convenience (57%), ability to receive care quickly (47%), and safety (36%).

- Pain, but no gain: Overall satisfaction with direct-to-consumer and payer-sponsored telehealth services was down in 2021 from the year before. Obstacles often cited by patients were limited services (24%), lack of information about costs (15%), confusing technology requirements (15%), and insufficient information about providers (15%).

- Uneven care for patients at higher risk: Overall satisfaction was 85 points down (on a 1000-point scale) among patients with the lowest self-reported health status than among those believing themselves to be in excellent health.

Heathier patients were more likely to comprehend information provided during visits, to perceive that their visits are personalized, and to obtain high-quality diagnoses.

 Rankings
JD Power ranked the top telehealth providers in direct-to-consumer and health plan–provided categories. In direct-to-consumer brands, Teladoc ranked highest in satisfaction with a score of 874. MDLIVE took second with 868, and MyTelemedicine was third with 859.

In the health plan–provided category, United Healthcare was tops with a score of 868, while Humana and Kaiser Foundation Health Plan tied for second with 865.

The survey measures customer satisfaction with telehealth service experience based on 4 factors (in order of importance): customer service (42%), consultation (28%), enrollment (19%), and billing and payment (11%). The study is based on responses of 4676 health care customers who used a provider in direct-to-consumer and health plan–provided categories. In direct-to-consumer and health plan–provided categories.

REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM

TO READ MORE, VISIT: https://bit.ly/2WFJof4
Compassion Fatigue? Talk About It
Rebecca Leach, MPH, BSN, RN, CIC: “[Compassion fatigue is] a hard topic for us because we’re not used to talking about this kind of thing in infection prevention. We’re very much focused on evidence-based care and standards. And so, this delves into a little bit of dealing with our emotions, right? And in health care, we don’t talk about that kind of thing.”
WATCH: https://bit.ly/3m1ruf7

CDC Epidemiologist Discusses Sepsis, COVID-19 Link
The CDC’s Runa Gokhale, MD, MPH: “I think that there is a role for infection preventionists to play here, and they are a community that we’ve been trying to engage through some of our sepsis awareness and sepsis prevention efforts.”
WATCH: https://bit.ly/3isM2Wj

Who Will Get Nursing Homes Off Life Support?
Linda Spaulding, RB-BC, CIC: “The time to hold nursing homes accountable is not the time when everything’s falling apart, and they don’t know what to do, and there’s nobody there to guide them.”

To see more interviews with expert clinicians and healthcare professionals, visit www.medicalworldnews.com

Notable Quotables

Clinically, SARS-CoV-2 combines some of the properties of the seasonal flu plus HIV. Similar to the seasonal flu, SARS-CoV-2 can primarily attack the lungs. But ACE2 receptors are everywhere. Similar to HIV, the virus can also enter a stealth mode, silently spreading throughout the host’s body and attacking almost every organ, especially those with a high ACE2 receptor concentration.

—KEVIN KAVANAGH, MD
FOUNDER AND PRESIDENT
HEALTH WATCH USA
READ MORE: https://bit.ly/3Fk4z0P

In our new publication in @ICT_magazine we discuss the importance of using community engagement to promote basic infection prevention and control measures at the individual level. “Without an Engaged Community, Infection Prevention Can Flounder” https://bit.ly/3la0ep2

DR. SYRA MADAD @syramadad

Let’s go Back to Basics! To best prevent and decrease infection, including antimicrobial resistance, we have to get back to the basics. All too often, we find that adherence to basic measures is lacking. - @ICT_magazine #infectioncontrol Read more here: https://bit.ly/3bmmmeg

SUREWASH @SureWash

If #COVID could talk...but it does, at the cellular level: interesting article from Joachim L Schultz, MD, professor of genomics and immunoregulation at the University of Bonn @ICT_magazine https://bit.ly/3ozeKZN

ELIS UK @ElisUK

Sepsis is a devasting condition that occurs in response to infection, made worse by drug-resistant infections. Diagnosing and treating earlier is critical. Read more via @ICT_magazine https://bit.ly/2YoHSYW

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How Hospital Administrators Can Help IPs Manage HAIs

BY HEATHER SAUNDERS, MPH, RN, CIC

Before the COVID-19 pandemic, hospital administrators were familiar with the purpose and vision of the infection prevention and control (IPC) department. When health care–acquired infections (HAIs) were high or outbreaks present, administrators would turn to their IPC colleagues to better understand what steps were being taken to reduce infection rates and prevent the spread of disease within the hospital. Despite their importance in the prevention and control of infections, some IPC departments have historically felt unsupported by hospital administrators. Occasionally, these departments have received little to no support for more full-time employees and no additional funding for prevention efforts. They also have had a limited role in making hospital decisions that ultimately affect infection prevention and control.
As COVID-19 spread, hospital administrators looked to IPC experts to determine how to protect employees, patients, and visitors. IPC quickly became one of the most important departments in the hospital. Infection preventionists (IPs) were at the table for every decision and department capacity was increased to sustain prevention and control efforts. The increased attention and support are what we have needed for decades to substantially reduce HAIs in hospitals.

The pandemic has had a detrimental effect on progress in reducing HAIs.1 (See table on page 18.) If we can harness the energy present between the IPC department and hospital administration during the pandemic, together we can become change catalysts, tackling HAIs with such gusto that the road back to zero infections will be paved in yellow bricks. But to accomplish this, we need a road map. We need defined steps that will lead hospital administrators and IPs along the path to improved patient safety with decreased HAIs.

**Hospital Leadership Support**

First, to see the changes we hope for in hospital IPC, we need the full support of hospital administration. For too long, preventing and controlling infections has rested solely on the IPC department. If we want sustained improvements in our hospitals, administrators must visibly show support for IPs while investing time, resources, and hospital funding to increase the capacity of the IPC department.

As Tamasin Adams, MPH, CIC, manager of infection prevention for the Lutheran Hospital of Indiana, states, “With the combination of administrative support and IP knowledge, new processes can be supported and implemented to keep patients and staff safe.” Yet many activities, such as increased surveillance for HAIs or electronic hand hygiene monitoring, will require additional staff and funding. Currently, many IPC programs barely have the capacity to keep up with mandatory HAI surveillance and reporting requirements.

Although HAIs tied to mandatory reporting and hospital reimbursement are priorities for the hospital, many other HAIs are being neglected due to limited staffing within IPC departments. With administrative support to increase infection prevention staffing, IPs could move beyond HAIs tied to reimbursement and target those not regulated by mandatory surveillance and reporting requirements.

**Frontline Buy-in**

Visible support from hospital administration increases staff buy-in for IPC efforts. Although IPs have the tools and knowledge to decrease HAIs, hospital administrators must make those efforts visible and rally buy-in from frontline staff. Without frontline support, efforts to improve prevention practices and mitigate the spread of infections will quickly fail.

One of the most overlooked methods for gaining frontline support is having existing relationships and trust with frontline staff members. When hospital administrators and IPs show their respect, trust, and support of frontline staff, those staff members will respond in kind. When we work collaboratively, we work toward positive change. During the pandemic, everyone throughout the hospital turned to the IPC department for answers.

**Back to Basics**

Once we have the full support of hospital administration and the buy-in of frontline staff members, we must get back to the basics of infection prevention to reduce the rate of HAIs. We must reemphasize the focus on basic practices such as good hand hygiene, proper use of personal protective equipment (PPE), and environmental cleaning and disinfection. These are effective strategies that will work again...
sustainable change. Jones says “it is about that our efforts fall short of producing with the best hands-on education, we find and the answer.” Sometimes, even Maryland, “Education isn’t always Pediatric Hospital in Baltimore, infection prevention.

Next, we need hands-on education with frontline staff. Finally, we must continue education through frequent reminders and signage about best practices for basic infection prevention. But according to Erica Jones, BSN, RN, CIC, director of infection prevention for Mt. Washington Pediatric Hospital in Baltimore, Maryland, “Education isn’t always the answer.” Sometimes, even with the best hands-on education, we find that our efforts fall short of producing sustainable change. Jones says “it is about engaging frontline staff in processes to understand their day-to-day and how to incorporate basic prevention principles into processes that are already in place.” It comes back to collaboration. Again, for prevention efforts to succeed, we must work as a team with frontline staff, listening to their perspectives and involving them in our efforts to improve the prevention and control of infections.

But listen closely, because this is important: None of this can be accomplished without the full support of hospital administration. The work ahead for IPs will take more administrative support and funding than ever. The COVID-19 pandemic has brought a significant rise in HAIs. The reasons are abundant but the solution is simple. We need administrative support to increase the capacity of the IPC department, we need increased funding and visible support from hospital administrators for IPC efforts, we need buy-in and involvement from frontline staff, and we need to return to the basics of infection prevention. But together, hospital administrators and IPs can stem the rising tide of HAIs in our hospitals. United, with increased support of the IPC department, we can sustain positive change in the prevention and control of infections.

HEATHER SAUNDERS, MPH, RN, CIC, is director of infection control at Johns Hopkins Office of Population Health in Baltimore, Maryland. She is also owner of and primary consultant for Broad Street Prevention, where she guides health care and business leaders in the prevention and control of infectious diseases.

REFERENCES


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Table. Health Care–Acquired Infections Are on the Rise

<table>
<thead>
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<th></th>
<th>2020 Q1</th>
<th>2020 Q2</th>
<th>2020 Q3</th>
<th>2020 Q4</th>
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<td>SSI: abdominal hysterectomy</td>
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<td>↓ -10.3%</td>
<td>↓ -8.8%</td>
<td>↓ -5.5%</td>
</tr>
</tbody>
</table>
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The Long Arm of MRSA

BY JAN DYER

The patient’s room may be a sanctuary of cleanliness, but what about outside? Outpatient clinics, radiology, physical therapy, and other such areas may be “underappreciated sources” of transmission of multidrug-resistant organisms, according to investigators from the Louis Stokes Cleveland VA Medical Center in Ohio. In a 6-month observational study, they found environmental shedding of methicillin-resistant Staphylococcus aureus (MRSA) during 45% of appointments outside hospital rooms or during outpatient clinic visits.1

Patients were screened for MRSA or multidrug-resistant gram-negative bacilli (MDR-GNB) upon admission, ward transfer, and discharge. Those with MRSA colonization or infection were placed in contact precautions (as were any patients with cultures positive for extended-spectrum β-lactamase–producing gram-negative bacilli or carbapenem-resistant gram-negative bacilli). For appointments outside patient rooms, staff at the appointment locations were alerted that the patient was in contact precautions. Clinical staff in sub-specialty clinics, radiology, hemodialysis, and physical therapy were responsible for cleaning surfaces between patient visits.

Of 50 enrolled patients, 39 were colonized with MRSA and evaluated for shedding during 53 procedures. Eleven MDR-GNB carriers were evaluated during 14 procedures. Patients were classified as shedding if 1 or more environmental cultures were positive during 1 or more procedures. All preprocedure cultures collected after cleaning and disinfection of surfaces were negative for the pathogens. The investigators performed χ² tests to identify patient-level factors associated with shedding.

Hardy Pathogen
No MDR-GNB were recovered from surfaces during 14 appointments. “We probably recovered more MRSA because it tends to be [hardier] and more able to survive on surfaces than multidrug-resistant gram-negative bacilli,” says Curtis Donskey, MD, director of infection control at Louis Stokes Cleveland VA Medical Center, chair of the Infection Control Committee at the Cleveland Department of Veterans Affairs, and an author of the study. He adds that conclusions that can be drawn about shedding of MDR-GNB are limited by the small number of colonized patients studied.

It was a different story for the MRSA carriers. Of those 39, 15 (38.5%) shed MRSA to the environment during 1 or more procedures, including 10 of 24 (41.7%) inpatients evaluated during appointments outside their rooms and 5 of 15 (33.3%) evaluated during outpatient clinic visits.

On the Rise?
Before last year, hospital-acquired MRSA infections had been in decline since 2010. Then came the COVID-19 pandemic. Investigators who used data from more than 3000 hospitals in the National Healthcare Safety Network (NHSN) to determine the impact of COVID-19 on healthcare–acquired infections (HAIs) say that, compared with 2019, 2020 saw “large and significant” increases in prevalence for hospital-acquired bacteremia.2 Preliminary data for the last quarter of 2020, for instance, revealed a jump of 34% in MRSA compared with the same quarter in 2019. Several states had much higher increases. In Arizona, for instance, rates leapt 80%; in New Jersey, that figure was 99%.

The investigators attribute some of the rise to the larger number of laboratory-identified events reported during those quarters in 2020. They also considered that diseases, general internal medicine, and surgery. Contamination was present only in the patient area after 4 appointments and only in the provider work area after 1 appointment (the provider used the computer after patient contact without prior hand hygiene).

Given that none of the shedding was due to MDR-GNB carriers, the investigators subsequently focused their analysis on factors associated with shedding by the MRSA-colonized patients. The only factor significantly associated with shedding, they found, was a wound positive for MRSA.

CURTIS DONSKEY, MD: “At this point there’s a lot of evidence on how pathogens are being shed. The next step is to see if there are some practical interventions we can implement to reduce shedding. We’re currently testing interventions like patient hand hygiene, antimicrobial clothing, and improved patient bathing.”

In all, 17 appointments resulted in environmental MRSA contamination. In those 17 instances, cultures were positive in the patient area. In 2 of the 17 cases, the provider work area was also contaminated, due to the provider touching the patient without gloves followed by contact with the work area without performing hand hygiene.

The 15 clinic visits were for infectious
the increase in MRSA bacteremia in 2020 might have been a result of inadequate central line insertion and maintenance practices, but preliminary NHSN data showed no substantial changes in 2020 in the proportion of central line bloodstream infections (CLABSSIs) caused by S aureus, or in the proportion of S aureus CLABSSIs resistant to methicillin.

Their is the first comprehensive look at the impact of COVID-19 on HAI incidence at the national and state levels, the investigators say. Their data analysis is still preliminary and doesn’t reflect all HAIIs in the United States in 2019 and 2020. However, they also point to a meta-study that found more than 25% of all infections in COVID-19 patients were related to S aureus, more than half of which were MRSA. Whether some of the MRSA bacteremia events reported to NHSN in 2020 were secondary infections in COVID-19 patients remains unknown, they add.

The increased focus on hand hygiene, environmental cleaning, patient isolation, and use of personal protective equipment during 2020, combined with continued inpatient antimicrobial stewardship programs, could only have been for the good. But these days, with patients, staff, and families still at risk for COVID-19 and its variants, “there’s a need for more attention to the risk for transmission of all kinds of pathogens in outpatient and ancillary care settings,” Donskey says. “In our VA facility, we found that most clusters of COVID-19 with nosocomial transmission occurred in outpatient clinics and ancillary care areas and predominantly involved health care personnel.”

Donskey says the Department of Veterans Affairs has had a strong national program focused on control of MRSA and other resistant pathogens for more than a decade. “The intervention has been associated with significant reductions in MRSA transmission and infections. One component of the program has been routine screening of hospital admissions for MRSA carriage. Knowing which patients are colonized with MRSA allows providers to implement control measures in inpatient settings and after discharge.”

Interventions
Donskey has spent the better part of his career narrowing down the who, what, why, where, when, and how of pathogen shedding. “At this point there’s a lot of evidence on how pathogens are being shed. The next step is to see if there are some practical interventions we can implement to reduce shedding,” he says. “We’re currently testing interventions like patient hand hygiene, antimicrobial clothing, and improved patient bathing.”

The investigators suggest that measures such as chlorhexidine bathing may provide “source control.” Only 2 MRSA carriers in their study were receiving chlorhexidine bathing—and neither shed MRSA. Of course, some basics should be de rigueur. Donskey cites a 2019 study that found intermittent decolonization of MRSA carriers with nasal mupirocin and chlorhexidine bathing after hospital discharge reduced the risk of MRSA infections. This type of intervention, he notes, could also potentially reduce the risk for shedding of MRSA during postdischarge outpatient visits.

“In outpatient settings, personnel typically don’t know what pathogens their patients may be carrying,” Donskey points out. “Simple practices like encouraging all patients to use hand sanitizer when they arrive for outpatient clinic visits or procedures can reduce MRSA and other pathogens on hands.”

Other steps include ensuring that mobility does not affect the disinfection. “We’re cleaning and disinfecting hospital rooms much better and now realize that we need to improve cleaning of equipment that goes from room to room and in outpatient clinics and ancillary care areas,” Donskey says. Transferring patients also carries risk of triggering a super-spreader event. Researchers in Belgium and Sweden developed a MRSA contagion model based on a data-driven model of contact patterns among 743,182 patients in a large hospital system. They found that, conservatively speaking, it would take 3.5 weeks for the infection to appear in a second hospital. Even for low infectious rates, they say, MRSA might reach up to 10 hospitals within a year after the initial infection.

Infections can be managed or prevented, but it will be a while before they disappear. Donskey is optimistic but realistic. “I think basic practices like hand hygiene and environmental cleaning have improved a lot over the past 20 years,” he says. “However, once we improve in 1 area, we always find other areas that need attention.”

JAN DYER is a writer and editor specializing in clinical topics. She lives in Suffern, New York.

REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM
As of early October 2021, there have been over 233 million cases of COVID-19 and 4.7 million associated deaths worldwide.¹ These numbers likely represent a significant undercounting due to asymptomatic and presymptomatic cases as well as access to testing, roadblocks to care, and the amplification of existing social and racial inequities. The COVID-19 pandemic has revealed many vulnerabilities in our health care and public health systems, but also in our ability to prepare for and respond to infectious disease outbreaks and pandemics.

Fundamentally, this has been a painful lesson in situations we thought we were better equipped to handle and weaknesses we had been ignoring. For so many of us working in infectious disease, public health, and infection prevention, many failures we saw were not unexpected. In fact, it seemed many were issues and red flags we had been raising for years, from inadequate pandemic planning in hospitals and other health care facilities to challenges in fit-testing large numbers of health care workers emergently and hurdles to getting enough isolation room.

These are things we knew would be problematic during a pandemic; they do not include the obvious factors like hurdles in quarantine/isolation in the community, science communication, health care and essential worker burnout, etc. Fundamentally, this pandemic has held a large mirror up to the world—but will we remember these lessons?

For infection preventionists (IPs), one of the biggest roadblocks was access to personal protective equipment (PPE), specifically masks, during the first year of the pandemic.² We always expected supply chain hurdles but nothing could have prepared us for how chaotic and worrisome this experience has been.

Role of IPs

Although IPs are not responsible for procurement of PPE, we work closely with the supply chain and procurement departments within health care facilities to ensure adequate supplies and review new ones to discuss quality, product availability, needs, etc. There is an intrinsic relationship between these 2 departments that was amplified during the COVID-19 pandemic.

When supplies—specifically of masks like N95s—began to dwindle, the realization hit: We will have to move to an emergency process and reuse or extend use of the masks we have been telling individuals for years to dispose of after caring for a patient. Soon, these shortages pushed us to evaluate the use of KN95 masks,³ which were not previously allowed in the United States because of a lack of quality assurance.

Following this, gowns and in some cases disinfectants become the hot commodity. While there were toilet paper shortages across the United States, we were increasingly just trying to buy what we could. As part of the problem, hoarding became an issue. To implement reprocessing of masks through disinfecting measures like UV radiation (UV-C) or to enable extended use, we had to centralize many supplies because of such shortages.

For many health care professionals, this gave the impression that masks were being withheld, which added stress, frustration, and distrust during

Many Masking Problems Can’t Be Masked

BY SASKIA V. POPESCU, PHD, MPH, MA, CIC

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an already complex, exhausting situation. This was perhaps one of the more challenging times, as IPs worked to communicate that masks were available or that there existed a process for obtaining them. Therein lies our role—a bridge between the patients or health care workers and ensuring safety through supplies, processes, etc. In this case, many of us felt helpless.

Like so many, we turned to alternatives that opened the door to more supplies or at least extended use. Disinfection and extended use became more common, with processes shared by organizations and agencies like the CDC. Another option was reusable elastomeric particulate respirators, which were made of rubber material and could be repeatedly cleaned, disinfected, stored, and reused. Per the CDC, “They are available as alternatives to disposable half-mask filtering facepiece respirators (FFRs), such as N95 FFRs, for augmenting the total supply of respirators available for use by HCP [health care practitioners]. [Although] elastomeric respirators are not cleared by FDA for fluid resistance, based on their NIOSH [National Institute for Occupational Safety and Health] approval, they can provide at least equivalent protection to N95 FFRs. Some types of elastomeric respirators can offer higher assigned protection factors than N95 FFRs.”

While we were addressing the other needs of PPE, the use of elastomeric respiratory opened the door to what the future may look like for infection prevention and masks in general. The hard part is whether we feel comfortable moving the needle when it comes to what we have always seen PPE as—a disposable mask and gown, etc.

Our approach to PPE and masks is a bit antiquated and now is the time to invest in innovation and pragmatic solutions, but we need to call upon the individuals who have experienced the hurdles of working in a pandemic. What We’ve Learned The lessons learned from COVID-19 will likely take years to truly understand. Perhaps one of the most telling comes from the front lines of health care in terms of masks and PPE. The issue is 2-fold—we need stronger supply chains for essential workers (and the public) to ensure adequate protection during emergent times, but we also need to start shifting how we approach PPE for health care workers. It’s worrisome when we must discourage the public from buying masks, specifically medical masks, to ensure adequate supplies for health care workers. As noted in the Washington Post: “Both the market for N95 masks and the national stockpile were small before the pandemic. The US imported at least half of its PPE, including medical masks, from China, where exports shrank for months because of the outbreak, said Scott Paul, president of the Alliance for American Manufacturing, a nonprofit organization that advocates for public policies to benefit US manufacturers.”

What We Need Ultimately, we need PPE that can be reprocessed both within a health care setting and at home—this issue speaks to bigger needs outside the hospitals and patient care areas. PPE that is single use can and does serve an important purpose, but one of the greatest hurdles we’ve had has been through continuously having to refit-test people when new masks come in that haven’t been used before. We need masks that can easily be fit-tested or are more moldable to ensure a good seal. Health care has such a significant waste problem and single-use PPE, like masks, is a prime example. To design more PPE like elastomeric respirators that can be reused and appropriately reprocessed would give us a significant advantage in times of stressed supplies but also ensure that we have higher levels of respiratory protection that are readily available and can be used by multiple health care workers.

Moreover, such masks should be more moldable to make fit-testing easier and more efficient. Having to redo fit-testing for health care workers when we ran out of one kind of N95 and got another brand in was extremely time consuming. There is a desperate need for us to think outside the box when it comes to PPE and to incorporate IPs and frontline responders into these conversations as well as conversations about research and development. Our approach to PPE and masks is a bit antiquated and now is the time to invest in innovation and pragmatic solutions, but we need to call upon the individuals who have experienced the hurdles of working in a pandemic.

SASKIA V. POPESCU, PhD, MPH, MA, CIC, is a hospital epidemiologist and infection preventionist. In her work as an infection preventionist, she performed surveillance for infectious diseases, preparedness, and Ebola-response practices. She holds a doctorate in biodefense from George Mason University in Fairfax, Virginia, where her research focuses on the role of infection prevention in facilitating global health security efforts. She is certified in infection control and has worked in pediatric and adult acute care facilities.

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**IAHCSMM’s Name Will Change, but Not Its Mission**

Come January 2022, the International Association of Healthcare Central Service Materiel Management (IAHCSMM) will officially change its name to the Healthcare Sterile Processing Association. HSPA should be easier to remember and many throughout the healthcare system will want to remember it because sterile processing professionals have been relied on heavily during the COVID-19 pandemic. As Damien Berg, IAHCSMM vice president for strategic initiatives, tells *Infection Control Today®* (ICT®) about how those professionals’ stock rose: “We got known.” Last month, IAHCSMM “got known” even more when it held its annual conference, with experts from around the world discussing how they improvised during the first wave of COVID-19 and the importance of proper management of water systems in warding off pathogens because stagnant water becomes reservoirs for bacteria, viruses, and fungi. Sterile processing professionals took center stage, which, since the advent of COVID-19, was not unfamiliar territory to them.

**Sterile Processing Unscripted: Know When to Innovate**

The US health care system was caught off guard when COVID-19 was declared a worldwide pandemic in March 2020. Infection preventionists and other health care professionals had to innovate in a hurry, the most obvious example being how to deal with the lack of N95 masks. Among the frontline workers who had to make do with what they had were sterile processing professionals. IAHCSMM held its annual conference virtually last month. One of the presenters was Berg, who was president of IAHCSMM’s board of directors in 2018 and 2019 and is now the organization’s vice president for strategic initiatives. The presentation by Berg and Amanda Benedict, vice president for standards for the Association for the Advancement of Medical Instrumentation (AAMI), was titled “Sterile Processing Unscripted.” Berg spoke to *Infection Control Today®* before his presentation about the innovations that sterile processing professionals had to come up with to function during COVID-19’s first wave.

*Berg*: Can you give an example of how this might work on the ground?

*Berg*: A good example is recently in Louisiana when we had the hurricane and there was immense flooding, power outages, and water outages. What people don’t realize is that the AAMI standards committee for 16, 17 years—I couldn’t find anything. And on the AAMI side, Ms Benedict, she was getting calls, emails, and questions from [individuals] like me asking: “What do we do when, basically, the standards don’t match the reality of what the world’s going through right now? How do I do it?” We said it’s sterile processing unscripted because we’re dealing with something that doesn’t have a script. We’re doing something that doesn’t have a [standard attached to it]. How do we do that? How can we create a pathway moving forward, so that whatever hits us next, it’s not this panic scenario on our part?

*ICT®*: What’s that all about?

*Berg*: It’s great. I do want to give a shout-out to my copresenter, Amanda Benedict, the vice president for standards at AAMI. She and I had this conversation a long time ago... during the first COVID-19 wave. There were several things going on, like reprocessing of N95 masks. They asked sterile processing departments to process 3D-printed items that I have never used and there are no standards that cover this stuff. There were a lot of things that happened during the COVID-19 time during the [FDA’s Emergency Use Authorization (EUA) act] that were confronting sterile processing professionals like myself. I manage a department for a large health care system and when I tried to reference standards—I have been part of the [American National Standards Institute and the AAMI] standards committee for 16, 17 years—I couldn’t find anything. And on the AAMI side, Ms Benedict, she was getting calls, emails, and questions from [individuals] like me asking: “What do we do when, basically, the standards don’t match the reality of what the world’s going through right now? How do I do it?” We said it’s sterile processing unscripted because we’re dealing with something that doesn’t have a script. We’re doing something that doesn’t have a [standard attached to it]. How do we do that? How can we create a pathway moving forward, so that whatever hits us next, it’s not this panic scenario on our part?
hospitals when the city water goes out, how are you getting your water? How are you getting your water to wash things? How are you handling that? There is no blueprint or anything to cover that. So, we wanted to say, when the water turns back on, how do you boil the water when you’re drinking water from the boiler? Water that you sterilize or wash your instruments with? We wanted to create blueprints for [individuals] to pick up and go so they don’t have to think on the fly. We want to give the leaders of either AAMI or IAHCSMM a tool to move forward with. That’s our presentation. We’ve got different areas we’re talking about: on the regulatory side, how standards are made and the rigor behind them. Then I’m going to talk about how that impacts the end users and my members and how they use those devices. Then, what are some examples when nothing matches either the education and/or the regulatory side? What do we get?

ICT®: You mentioned hurricanes and the electricity going out. I imagine that AAMI and IAHCSMM already had protocols about what to do in emergencies. Was COVID-19 just something so unusual that they didn’t apply?

Berg: Most facilities have emergency operation plans. But it’s tough to write a standard or metric. You can be educated on certain points. Honestly, with COVID-19 and Emergency Use Authorization, that changed the dynamic. Never in modern history can I remember being allowed to do things that we would never have been allowed to do before. Again, I use that idea of reprocessing the N95s or reprocessing [personal protective equipment]. We were [previously] just told, “No, you can’t do that.” Once that was allowed, then other things happened. We were approached by the end users about all kinds of methods. “Well, hey, what about using this now, but you can’t do this.” You open the door for it. Now you can do this. The industry people love it. This is where I think back to the Industrial Revolution and those times when America was creative, creating stuff nobody ever saw or thought of. People in the industry were really being creative with 3D printing and/or coming up with new devices to substitute shortages in the supply market, that we’ve never seen before. There literally were no standards to develop around that or education around it. They basically kept saying, “Why can we do it with the N95 mask and not with this?” We wanted to talk about that and say, “This is the way we need to address this moving forward.” And industry… it is awesome that people are thinking outside the box to solve [problems] in the real world. But we also want to make sure we’re doing it safe for the patients and the providers using these devices that we reprocess. Also, it’s reproducible. I can almost guarantee that I can sterilize and clean anything once. Can I do it multiple times with the same efficacy? That’s the rigor you need to put behind this. It’s like giving your kids permission to do something, and then you say, “Sorry, never mind. You can’t do that now.” And they’re like, “Wait a second. You can’t tell me I can do it, then tell me I can’t. You can’t say it was safe for me, and now it’s not safe. What’s the difference now?”

ICT®: It sounds like you’re talking from painful experience here.

Berg: Yes, sir. Also, one thing I didn’t tell you, and it’s something about me. I also spent 21 years in the military as a combat medic and [found myself in] my background—able to show that we put some rigor behind doing it. We just didn’t listen to the noise out there. We didn’t listen to everybody saying, “Just do this” and run around like Chicken Littles shouting that the sky is falling. We did testing on N95 masks. We did documentation. I was able to track every mask to every reprocessing cycle to every end user and the number of times… The steps are so if there ever was an adverse event or outcome later, I was able to trace it back. But I also said at a certain point, we need to stop doing this because the supply chain will be back to normal, which it is in certain spots. It’s still wavy. But it has created that pull/push from the end users saying, “Well, I got this pin and I’m going to go and sterilize like we did with the N95s.” We have to say, “Well, that’s just not how we do things. Right now, we’re following policy, because there are no emergencies.”

ICT®: You mentioned that you were a medic and I want to thank you for your service. You have to be a special kind of person to be a medic.

Berg: During the presentation…I’ll be using some of those real-world examples. There were things you just had to do, because you didn’t have an option and you had to go through with it. It was
about explaining the “why.” So, the N95 masks—we literally knew our burn rate for them. And if we didn’t move—and we use UV light reprocessing at my health care facility—if we did not do that, the “why” would be that we would run out of masks in 5 days. That was our approach—thinking outside the box, using research from other institutions that are well renowned and had some stuff done to say, “OK, this is how we’re going to do it.” We got a multidisciplinary team together to come up with a process and the “why” behind it. “Why” wasn’t because we just wanted to do it, but because if we didn’t do it our care providers and our patients and we wouldn’t have N95 masks when we were treating the first wave of COVID-19. We really had to say: “This is the call to action.” On the military side, I’ll give a graphic example. I was in the field for a unit and I did not have surgical gloves or sterile instruments. I had to go inside someone’s inner body cavity with my bare hands and instruments that I sterilized on my own to stop the bleeding. The “why” was if I didn’t do that, that person would die. What would impact a patient greater: Me not having sterile gloves and me getting exposed to their blood, or me just saying I don’t have them so I’m not going to do anything? You must make choices. Those are 2 extreme examples. When I have to do things in this world now, I always use the old method. I check my pulse, and if I have a pulse, then I can calm down and move on. I don’t get too excited about things anymore. I just think through them differently. That’s unscripted, because you’re going to have those unscripted moments where you can’t wait for the regulatory folks to say, “Do this.” You’ve got to use some common sense but also your science and background and then do what we call in the military an action review. You look backward and say, “OK. What did we do? Why did we do it? How do we do it? And do we need to change anything on why we did it?” I think the same thing really applied to this road map. I had some [individuals] do some soul searching and ask: “Do I really want to do this profession anymore?”...The level of stress that they went through, they probably never experienced in their lifetime. There are different levels of stress and [individuals] handle it differently. They’re just kind of soul searching, saying “Is this really what I want to do? Am I close to retirement? Should I just retire? Or do I switch career paths and do something different?” That’s fine for everybody. I look back and think, “Boy, we did some innovative stuff.” I’ll give you some good examples. Where sterile processing really was—and it’s still holding true; it’s a byproduct of COVID-19—we were looked at, because we’re the cleaning disinfection and sterilization experts in the facilities...People didn’t really know that. COVID-19 put a light on sterile processing professionals in a positive way. We became a force multiplier in the hospital by the things we did. And we got known. We got asked more questions about: Is this contact time right? What’s the dwell time? What’s the chemical ratio? They didn’t know what dwell time was prior to COVID-19. Not the masses. They didn’t know what contact time was. They just did their thing. But now they rely on us as subject matter experts. To me, that is a longer-lasting thing to keep me in the profession vs the small lap or the stressful intense time of the first wave…. Now we’re dealing with multiple smaller waves that are hitting, but we’re using those lessons learned. That passion for what we do is to keep moving forward.

REFERENCES

To watch the full interview, scan the QR code
Troubled Water Makes for Sick Hospitals

Water needs to flow in hospitals and office buildings because stagnant water and/or the pipes it sits in can quickly become reservoirs of pathogens. That’s a message Brian Flannigan, vice president for corporate sales and business development with Phigenics, an Illinois-based water management company, brought last month to the annual conference of the International Association of Healthcare Central Service Materiel Management (IAHCSMM). Too often during the COVID-19 pandemic, water was shut off and stayed off for long periods, which caused many problems, Flannigan tells Infection Control Today®.

“Water treatment equipment and water systems are not designed to operate sporadically,” says Flannigan, whose presentation was titled “Water Safety & Quality During Medical Device Reprocessing.” He continues: “They operate much better whenever they operate continuously. There have been a number of operational issues that have arisen during the pandemic around sterile processing during operations and during the restart of operations.”

He said the result of this is much greater awareness in and outside of health care about the importance of water management. “We have seen and recognized many of the health care heroes, the ones on the front lines who responded to the pandemic and the heroic efforts that they provided to support patients coming through the door,” said Flannigan. “What we haven’t seen necessarily are the behind-the-scenes folks who have been responsible for [managing] the infrastructure of those hospitals.”

Flannigan said, “We are strong proponents of the multidisciplinary team and the benefit that that brings.” That team should comprise infection preventionists, environmental services (EVS), building management, and, of course, sterile processing professionals. It needs to follow standards mandated by the Centers for Medicare & Medicaid Services (CMS), standards that mirror those created by the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), Flannigan says. ASHRAE Standard 188 contains specific benchmarks when it comes to managing waterborne pathogens and water systems.1

“CMS said that a health care facility had to have a water management program in place,” says Flannigan. “This risk management process for water systems starts with a multidisciplinary team. As you can imagine, the facility engineers… are on this team. But a key player on that team is always infection prevention. We’ve seen that the water management programs in some hospital systems are driven by infection prevention as opposed to facility management. But in all cases, they partner with others in the hospital.”

EVS workers play a crucial role in ensuring that water doesn’t become contaminated. “As they clean the rooms, they are often tasked with making sure they run the fixtures in the room,” says Flannigan, who adds that in many rooms, patients are often too sick to shower or use the sink. “Very sick patients may not see water usage for weeks at a time,” says Flannigan. “EVS is how most hospital systems and water management teams make sure that water flows through the fixtures and that the disinfectant they have in the water systems has a chance to be effective.”

Although infection preventionists and EVS members staff the water management team at many health care facilities, it is significant that Flannigan is making his presentation at the conference of the largest organization representing sterile processing professionals.

“The reason why water quality and water safety are so important in sterile processing is that there have been direct connections made between the water systems and hospital infections: operating room infections, asset life problems, maintenance problems, staining and discoloration of equipment.”

BRIAN FLANNIGAN: “The reason why water quality and water safety are so important in sterile processing is that there have been direct connections made between the water systems and hospital infections: operating room infections, asset life problems, maintenance problems, staining and discoloration of equipment.”

REFERENCE

To watch the full interview, scan the QR code
What Awaits You at IDWeek 2021

The cliché that once something goes online it’s there forever might be debatable among computer forensic specialists, but it’s true enough. That’s a good thing when covering a conference. Although IDWeek 2021 happened a while ago (from September 29 to October 3), it remains ongoing thanks to the internet. Simply google IDWeek 2021 and the top result is https://idweek.org where you may register and view the presentations as they happened in real time.

*Infection Control Today*® was able to interview Joshua Nosanchuk, MD, programs chairperson for IDWeek 2021, and Monica Gandhi, MD, MPH, a panel moderator. Both are well known in the field of infection prevention and control. Nosanchuk is senior associate dean for medical education at Albert Einstein College of Medicine and Montefiore Medical Center, both in New York, New York. Gandhi is associate division chief (clinical operations/education) of the Division of HIV, Infectious Diseases, and Global Medicine at the University of San Francisco and San Francisco General Hospital in California. Both have the highest respect for infection preventionists (IPs) and the work they do.

IPs Are “True Blessing”

When IDWeek 2021 kicked off, Joshua Nosanchuk, MD, programs chairperson of the conference, extended a warm welcome to all health care professionals dealing with infectious diseases, including IPs. He specializes in treatment of fungal infections. In a wide-ranging interview with *Infection Control Today*® (ICT®), in addition to discussing the important role IPs play in infection prevention and control, Nosanchuk talks about how to handle medical misinformation, the structural determinants of health, the importance of fostering a worldwide community of medical professionals dedicated to fighting infections, and the challenges involved in running a virtual conference—and, of course, what the health care system has learned from the COVID-19 pandemic. “The care of a patient with COVID-19 today in my hospital—compared with early March 2020 when we first had 1, then 2, then 20, then 2000 at a time in our hospital—is night and day,” Nosanchuk tells ICT®. “It’s just incredible.” The interview took place right before the start of IDWeek 2021.

*Infection Control Today*®: Let’s start with what you specialize in. Just how much of a challenge do fungal pathogens present to the health care system?

**Joshua Nosanchuk, MD:** Over the past several decades, we’ve seen more fungal pathogens. With the explosion of HIV in the 1980s, with more extensive regimens for treating different cancers, with all the newer biologics that we’re seeing, we’re seeing tremendous numbers of these cases in our patients. Many of these organisms are all around us. We breathe them in almost every breath we take. If you have a compromised immune system, it can be overwhelmed. Similarly, there are some [that healthy] individuals are susceptible to. [For example,] coccidioides, which is a fungal pathogen found mostly in the southwestern United States as well as in Latin America. If there’s a dust storm out in the San Joaquin Valley and you breathe in some of those spores, anybody can come down with a very significant illness. There’s such a remarkable range in these organisms. Fungi are very similar to humans in terms of their structure and machinery, and so many of the drugs that we would really like to develop would also be toxic to us. The drugs that we give many of them like amphotericin, and the azoles like fluconazole, can have toxicities in ourselves as well because of similarities with cholesterol, for example.

ICT®: That seems a serious problem in terms of treatment. How do you approach that?

**Nosanchuk:** First, we need to make sure we consider these in our differentials when we’re looking at a patient. We must aggressively pursue appropriate diagnostics. Diagnostics for fungi have continued to lag. Once we know a patient has these diseases, some are easy to treat in terms of duration of therapy. For *Candida albicans*, line infection—most of the time that’s a 2-week treatment.
But for certain infections—there’s one called paracoccidioides, which is mostly found in Latin America—we treat those individuals for at least a year and sometimes for life. They’re really complicated. We must think about vaccines for certain groups of individuals, particularly [those] who live in certain areas and may be at high risk. We must continue to develop newer medications. There are some now in the pipeline. But we haven’t had many new things for armamentarium against fungi.

ICT®: Regarding IDWeek, you’re the chairperson of programs. My core audience comprises IPs, most of whom have a nursing background. What’s on the agenda that you think will be of particular interest to IPs?

Nosanchuk: There’s a lot that’s happening and some of it has already begun. There are some premeeting workshops on antimicrobial stewardship and on infection control that are very important. Some of these are focused more on trainees and others are for experienced individuals. One of the important things about our meeting is that over the past several years, we’ve increasingly focused on structural determinants of health—not just dealing with the immediate problem but how and why do [individuals] end up with these diseases? How can we prevent that from happening? How can we prevent it as [individuals] move forward from whatever acute crisis they’re having? COVID-19 has also shown very marked structural determinants that have influenced certain communities. For example, where I am in the South Bronx, [consider] individuals who developed COVID-19 back in April or May 2020. If they went home to isolate there was no place for them to isolate. They were living in multigenerational houses with only 1 bathroom; very different than somebody who’s more affluent and may have many different rooms in their house where they can go. [We need to be] thinking about not just the incidents where you’re engaging with that patient in a nursing home or hospital, but what’s going on in society and communities more broadly. The other thing that I’m very happy about with our IDWeek is that we’ve tried to have robust presence of diverse individuals for speaking. Over the past many sessions, we’ve had at least a 50/50 split of men and women as speakers. For this year, we have at least that as well. That’s important to share. We have incredible talent across our field [that includes] PharmDs who are now a major force in our societies, as well as physicians, as well as our nurse colleagues. It takes an interdisciplinary approach to be successful at addressing some of these weighty issues. One of the things we’re all focusing on is misinformation. There’s a nice session on misinformation and public health, and what we can do better. There’s one that’s entitled “A Psychological Vaccine Against Misinformation” by [Sander van der Linden, PhD], who’s coming from Cambridge University against fungi.

ICT®: You use the term “structural determinants of health.” I’ve heard of social determinants of health. Is there any difference?

Nosanchuk: It’s similar. It has just been changing to that newer term over the past 3 years or so. It’s because there are so many facets to it. It’s not just social. There are other aspects in terms of race and gender. It’s become a broader term to try and catch more of the influences that come in and affect someone’s wellness.

JOSHUA NOSANCHUK, MD, PROGRAMS CHAIRPERSON FOR IDWEEK 2021: “[Individuals] want to be heard. They want their concerns and their fears to be able to be aired; coming in and just telling them that they’re wrong is not always a very effective way of convincing [individuals] to change.”

ICT®: You talked about the problem of misinformation. Was that a problem in terms of how you went about organizing the IDWeek conference? Did you have to sift through a lot of data that just didn’t make the grade?

Nosanchuk: We have an abundance of riches in terms of the [individuals] who can speak toward these very complicated processes. We’ve also expanded to
get individuals outside of the common groups that we frequently used [in the past]. We now include social researchers. We include many more PharmDs. We include many more nurse practitioners. When I started going to IDWeek it was only infectious disease faculty. Occasionally for some of the basic science work, we would have professors in microbiology or immunology talking. We've become much more inclusive in who we are inviting to speak. We also have grown into an international meeting. We're including a lot of international folks. Last year because of COVID-19 and switching to virtual and trying to figure out the best way to deliver important information...we started something called Chasing the Sun, which started with US investigators and clinicians, and then we included our colleagues from around the world. We're doing that again this year. That hopefully will be interesting. We'll finish with [Rochelle Walensky, MD, director of the CDC] giving a nice presentation on the status of where we are. The status is continuously moving. You may have noticed that there's been a lot of controversy over a third shot for the mRNA vaccines, and there have been [individuals] weighing in on over the course of this pandemic has been incredible: the numbers of papers, the numbers of drugs that have been assessed, and some of them have moved in and made an incredible difference. The care of a patient with COVID-19 today in my hospital—compared with early March 2020 when we first had 1, then 2, then 20, then 2000 at a time in our hospital—is night and day. It's just incredible. There are new data about things like remdesivir as an outpatient drug, reducing hospitalizations, and improving outcomes.

**ICT**: To go back to your statement about misinformation: Do you use preprint studies sometimes? How do you decide which are worth keeping and which are not?

**Nosanchuk**: That is an incredibly important question. It's hard. There are preprints that have come out of leading institutions that have then gone under fire afterward. You really must look at the data very carefully. You must look at whether they've defined what some of their shortcomings are. If they don't describe what their shortcomings are, that raises red flags that they really were missing some things. The preprints have been very useful for investigators because they allow them to put a placeholder in their research. When somebody else comes through and has something published, they can show that they had this information. This has been a challenge for a long time. I had, at one point, published a paper on a novel gene knockout method for the fungus *Candida parapsilosis*. We had shared that technique with a colleague and ours was published in *The Journal of Clinical Investigation*, which has a long lag time from acceptance to publication. My colleague published her work in a journal that had a very rapid [time from] acceptance to online presence. When my paper came out, there were [individuals] saying, “This isn’t new. So-and-so already published it.” Being able to put things into one of these preprint servers has been helpful for the scientific community in general. But it also doesn’t mean everything in that realm is going to get published [in a peer-reviewed journal]. It hasn’t undergone the scrutiny, which is so important. Some journals have a very low threshold for publishing and there are a lot of predatory processes out there requesting you publish in their journals for a fee. Almost all journals now require a fee. One called *Cellular Microbiology* that used to be free has now moved onto a new platform and will no longer be free. The folks like myself, we get at least 2 to 5 emails a day from different journals saying, “Respected sir, please submit a paper to our journal. We’ll give you a very fast turnaround time.” There’s been literature where people have put things like “rubber ducks” or various random words into their manuscripts and they’ve gotten published. You must look at where things are being published to validate that it’s real. Some of these journals are also on PubMed and on other respected networks. How do you really determine whether something is valid? That gets to carefully reading the information. If there is an editorial that goes with it and analyzes some of its positives and negatives, and this individual who’s written that editorial is somebody well known in the field, that can help as well. More respectable journals will often do that with their impactful findings. The other thing I will say is that time from submission to

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**JOSHUA NOSANCHUK, MD, PROGRAMS CHAIRPERSON FOR IDWEEK 2021**: “What the IPs are doing is a true blessing for our community and not always as well recognized as it should be....I just want to say thank you to all the [individuals] who are doing this work.”
publication, especially for things about COVID-19, was significantly accelerated. Many more things were published online before [they were published] in print through these journals to get that information out and to show that it was peer reviewed and validated in their eyes as being worthwhile for sharing with the community.

ICT®: How much of a challenge is it to run a virtual conference? Are things being done at this virtual conference that you think will remain in place even after we’re able to meet face-to-face?

Nosanchuk: An important question. When we had to switch a year ago to virtual, we had a very short turnaround time and the platform did not work as well as we would have liked. We looked at different platforms and picked Juno, which is the one we’re using now. So far, we’ve been very pleased and impressed with how that’s been functioning. I think we will maintain some of these simu-live activities. I will also say that [during] the last in-person IDWeek that we had, we did stream several of our higher-impact programs, especially some of the named lectures. We were testing it. I was in an office watching instead of in the room, just to see how it would look and how well the fidelity was. We were impressed with it. We were planning on doing more of that last year. But we didn’t because we were fully virtual. We’ve been talking about what to do in the future. We are very hopeful that IDWeek 2022 will be in person and discussing what types of things should still be broadcast live and how we would be able to do that in a way that we’ll still have [individuals] coming. Because it is something that is incredibly easy to stay home and watch. I watched probably 3 times the number of sessions last year virtually then I would have if I’d been there. If I’d been there I would have been meeting with colleagues and sometimes not even making it into the room, because you’re in an interesting conversation. Whereas at home, I was able to watch and, in the breaks, instead of going to the poster hall and again meeting with colleagues, I watched another of the seminars. I thought it was incredible how much information I was able to get. We also kept the portfolio open all year. We were able to share that forward with the attendees. Certain sessions were impactful. One was on some of the real ravages of COVID-19 on societies. One of those we were able to get released so that, for example, the medical students at my school were able to watch because it was so impactful. So how are we going to do this? It’s unclear what platform we will be using in the future. We really want to get through this year’s meeting and [look at] some of the new interventions—especially having [individuals] come back live after the prerecorded presentation to do a Q&A, which we couldn’t do last year—and see how that goes. We really do want to get international folks to the meeting, especially from some of the developing countries. One of the things I often see is manuscripts or poster abstracts from individuals from lower-resource countries that are missing some key things that you really would want to see in the work to make it more robust, and having those individuals come in and meeting and talking with them. Introducing them to collaborators can expand their capacity to do research and discovery in the future. It’s important to try and have international folks coming in person. Many of them also will go and visit an institution or two while they’re here in the United States because if you’re going to spend the money and come, meeting with other colleagues is often very valuable. I do the same thing. If I go to a meeting in Brazil, for example in Sao Paulo, I’ll go and visit colleagues I’ve been collaborating with in Rio de Janeiro. It is important to foster those cross-talks and develop new collaborations because they have resources we don’t, and we have resources they don’t. Together, we can always be stronger.

ICT®: Walensky is going to give a presentation?

Nosanchuk: Dr Walensky was one of the chairs of IDWeek in the past, so she is very well connected with the Infectious Diseases Society of America and IDWeek. She has been a wonderful colleague and asset to all of us. We often do have very well-known keynote speakers, [individuals] from [the National Institutes of Health (NIH)], the CDC, and the [World Health Organization]. [Anthony Fauci, MD, director of the National Institute of Allergy and Infectious Diseases] launched our Chasing the Sun [global broadcast] last year, and that was incredible to have him start out with that. This year, [Barney S. Graham, MD, PhD] who is from the NIH, will be launching Chasing the Sun. We have been very fortunate to have significant individuals in public health, epidemiology, stewardship, and infection prevention give these major talks at IDWeek. We’ve had [individuals] from the [Bill & Melinda] Gates Foundation and other impactful foundations come and participate as well. We try to bring individuals who will inspire and who have made major changes in the way we address the challenges in our field.

ICT®: Speaking specifically of IPs: What do you think they’d find compelling on your agenda?

Nosanchuk: I think it’s remarkable when you go through the agenda [concerning] what addresses infection protection. Because how do you look at infection prevention? Is it through having improved diagnostics, so you can have a quicker knowledge of somebody being ill or not ill and therefore put in faster infection controls to isolate or otherwise restrict access to that patient’s room? Is it about having better medica-

Discussing Pros, Cons of Universal Masking Post—COVID-19

BY FRANK DIAMOND

To appreciate just how fast COVID-19 moves and mutates, the topic for a panel discussion at this year’s IDWeek 2021 was “PPE in the Post-COVID World: Is Universal Masking the New Standard?” Monica Gandhi, MD, MPH, chaired that panel and recently told Infection Control Today® (ICT®) that the topic had been chosen before the Delta variant of COVID-19 surfaced. “That was a time when things were getting so much better,” Gandhi tells ICT®, “And it was a true question: Do we need to universally mask in health

so that [individual] can then come back into the community? I look at infection prevention as an incredibly broad net; basically, how do we prevent [individuals] from getting sick? But once they are sick, how do we most rapidly and efficiently make them better and keep them from spreading this disease to other [individuals]? It also is structural in terms of gowns and gloves. What are the right kinds of gowns and gloves? COVID-19 is another example of the fact that we weren't sure what to do very early on in terms of wearing masks in large gatherings: wearing an N95, wearing a face shield. There's going to be information on this. There is a session on appropriate gowning and gloving in long-term care and nursing homes. There's also a session about how we are going to emerge from this pandemic. It's called “Emerging IP Issues Outside of Acute Care: There's No Place Like Home.” Focusing on personalized infection control within various settings. There's one [called] "Infection Prevention in Long-Term Care: Finding the Silver Lining After COVID-19," Infection prevention when the home becomes the health care setting. There are interesting presentations that will energize the community, leading to more questions and hopefully new studies that will give us better answers in terms of how to prevent certain diseases. If you have something like Clostridioides difficile and you have these spores that are so resilient, how do you treat a home of a patient who has this, when they develop it at home, come into the hospital, and go back to home again? Should we have some type of process to clean the home or to clean everybody's shoes in and out of that home? There are a lot of unanswered questions. Having communities come together and ask these is the best way to start addressing them in the future.

ICT®: Dr Nosanchuk, is there something I neglected to ask that you think is pertinent to this topic and that you'd like IPs and other health care professionals to know about either fungal pathogens or IDWeek?

Nosanchuk: We must always be on our toes; frontline individuals like IPs sometimes are the first to start seeing and figuring things out. Over the past several years, we have [had] Candida auris, but we’ve also had Zika, we’ve had Chikungunya, we’ve had Ebola. We're going to probably see more diseases coming as the world continues to get smaller, and we have climate change that is disrupting so many areas of our lives. I just would advocate for [individuals'] ongoing vigilance. The other thing I would say is that what our community is doing is so incredibly important. When I teach the medical students, one of the things I want them to always remember is that washing their hands is one of the most important things they can do for the wellness of their patients. Simple things like that, always stopping to think, “Let me wash my hands. Let me wash my hands after.” Constantly putting infection prevention ideas and processes in place is what will keep our community the safest. What the IPs are doing is a true blessing for our community and not always as well recognized as it should be. Even though you think “maybe I'm just doing the same thing over and over,” it’s an incredibly impactful activity that changes lives and saves lives. I just want to say thank you to all the [individuals] who are doing this work. Over my career, I’ve seen it improve and continue to improve and it’s so impressive.

This interview has been edited for clarity and length.

REFERENCE


care settings? Then Delta hit and because of that the talk changed. All of our talks changed because we thought we were emerging from the pandemic when we designed this session.” (IDWeek 2021 was held from September 29 to October 3.)

As of this writing, the Delta variant appears to be waning, so Gandhi says: “The question still stands: When we get through this, will universal masking be standard?”

The answer is that universal masking will be the standard in health care settings for the foreseeable future but not for the long term, said Gandhi, a professor of medicine and associate division chief (clinical operations/education) of the Division of HIV, Infectious Diseases, and Global Medicine at the University of San Francisco and San Francisco General Hospital in California.

Universal masking in society will not happen in the United States for various reasons, said Gandhi. For one, the CDC is considering easing masking guidance for indoor settings. For another, too many in the public would simply ignore such guidance. “I think that we have too many mixed feelings here, and it won’t be recommended universally,” Gandhi said.

There are several factors at play when considering universal masking in health care facilities, said Gandhi. Infection preventionists (IPs) or other health care professionals work around vulnerable patients. They are also working in environments that might be contaminated by COVID-19. “We all agreed that universal masking is necessary now, and likely for quite a long time,” said Gandhi.

**PRO:** Health care professionals work with vulnerable patients, and in environments that might be contaminated by COVID-19.

**CON:** Patients want to see their caregivers’ faces.

However, the panel couldn’t agree on whether universal masking should be standard for all patient interactions forever. Both the patient and the caregiver would likely be vaccinated, and possibly be sitting 6 feet away from each other quietly discussing a course of care. It’s the sort of conversation that patients and primary care physicians often have.

Gandhi cited a famous randomized controlled study published in 2013 in *BMC Family Practice* that showed patients weren’t as comfortable talking to practitioners wearing masks.1

“There was a very clear, statistically significant difference that patients felt there was a loss of empathy in the interaction,” Gandhi said. "Primary medicine interaction that occurs in the outpatient setting, that’s a very strong connection. So, again, I don’t think we’re going to be universally masking in the future forever.”

If universal masking continues for a time in the post–COVID-19 world, then IPs will need to put that on their checklists. Gandhi said IPs “are going to have a really important role in maintaining surgical masking... for at least 6 more months.”

**REFERENCE**


Find these articles about APIC’s annual conference on *Infection Control Today*’s website.

| IPs in Early Stages of COVID-19 Were Needed to Point of Exhaustion | When Exhausted Infection Preventionists Saved the Day | Quick Infection Prevention Response Stymies C. Auris |
Partnership Offers Jobs to People With Disabilities

Three organizations find themselves at the intersection of manufacturing and human betterment. The manufacturing company Bollé Safety has partnered with SourceAmerica, a company that seeks to find employment for people with disabilities. SourceAmerica connected Bollé Safety with New Hope, a Texas-based not-for-profit organization with the same mission. In the case of this particular partnership, the jobs will entail the employees manufacturing safety eyeglasses and goggles.

Corey Heritage, SourceAmerica’s vice president of business development, says in a press release that the 3 organizations “are creating jobs, bringing safety eyewear to those who need it, and at the same time stimulating the economy with a product that will be assembled in America by a talented workforce of individuals with disabilities.”

Peter Smith, CEO of Bollé Brands Group and president of Bollé Safety, stated in the press release that “we’re very proud to partner with SourceAmerica and New Hope to help advocate for the value of people with disabilities in the workplace....”

According to the press release, Bollé Safety products are worn in over 100 countries in all sectors of activity in which there is a risk to the eyes and face, including in health care settings.

www.bolle-safety.com/us/  
www.sourceamerica.org  
www.newhopeinc.org

Trying to Get Better Handle on Sharps

One thing that presumably remained constant throughout the COVID-19 pandemic—and may have in fact become even more of a problem—is that sharps injuries remained a major occupational concern for infection preventionists and other health care professionals. Healthmark Industries thinks it may have reduced the threat of injury from sharp medical devices with the launch of its new product, Instrument Protectors. The product is part of Healthmark’s Instrument Care product line.

“‘The single-use Instrument Protectors provide protection for sharp and fragile items to the point of use,” the company said in a press release. “Manufactured from SBS [solid bleached sulfate] paperboard, the Instrument Protectors are equipped with a mounting surface to hold items in place to prevent them from sliding around or out.”

The product ensures easy retrieval from packaging thanks to a finger hole, the company says. It comes with an expandable base that accommodates both curved and larger items. An open window allows for better exposure.

“The Instrument Protectors are available for purchase in boxes of 100 and are offered in the following sizes: 5.5 x 9.5 in, 3.5 x 6.75 in, and 1.75 x 8.25 in,” the company says in the press release. Healthmark has been manufacturing devices for health care since 1969.

www.hmark.com

Manufacturer: Device Maintains Body Temperature

Maintaining a patient’s normal body temperature can do a lot toward ensuring the success of an operation or procedure. However, forced air warming systems carry with them the increased risk of infection. Encompass Group—a manufacturer and marketer of reusable textiles, professional apparel, and disposable and single use medical products—thinks it’s come up with a solution to this problem.

Encompass recently received notice of issuance of a patent from the U.S. Patent and Trademark Office (USPTO) for its new Nova patient warming system.

“Nova combines a unique Thermoflect metalized fabric exterior layer with a proprietary carbon heating layer—managed by an external control panel—to warm patients without air movement,” the company says in a press release. “It works by banking a patient’s heat before surgery and maintaining normothermia throughout the surgical process. This helps reduce the infection risks associated with forced air warming systems.”

The company points out that the fact that Nova has no moving parts eliminates the potential for distraction in the operating room. It helps both patients and caregivers because it’s simple to apply and stays in place, the company says. It’s easy to use and doesn’t generate excess heat: Patients stay warm, while health care professionals stay cool.

Eric Howard, vice president and general manager of the TECHStyles division of Encompass Group, says in the press release that “the many benefits of maintaining patients’ normothermia are well known. It helps improve patient outcomes, mitigate surgical site infections, limit hospital stays, enhance patient comfort, and reduce the cost of health care. And now, with Nova, clinicians have a better way to help patients do better.”

www.encompassgroup.com
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1. GHX Intelligence Date 2020 Q4
2. In comparison to weight of plastic for similar canister format; data on file